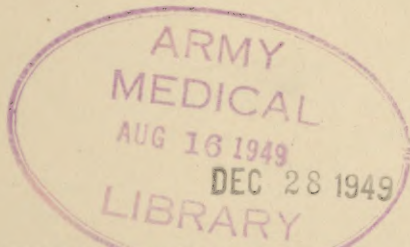
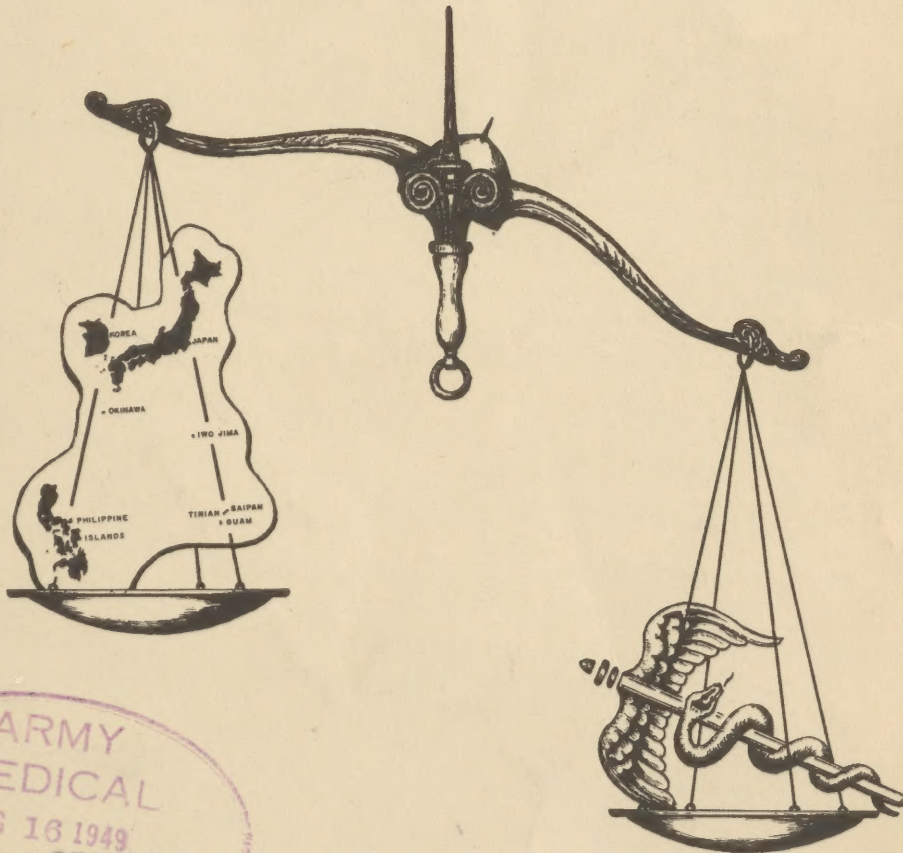


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DOCUMENT SECTION

MED. SEC. GHQ. FEC.

VOL IV No 8
1 AUG 1949



A FAR EAST PERIODICAL OF MEDICAL DEPARTMENT INFORMATION

SURGEON'S CIRCULAR LETTER

RESTRICTED

RESTRICTED

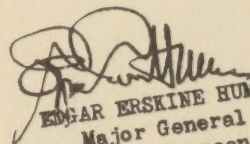
GENERAL HEADQUARTERS
FAR EAST COMMAND
APO 500

TO: All Medical Department Personnel, Far East Command

The devotion to duty of the men and women of our Department in this Command has been great. This I know thus far only by hearsay, but soon I hope to visit each of the units of the Command, meet our commissioned and enlisted personnel, see our installations, and learn of the problems which must be faced.

The record of the Medical Department of the Army in war and in peace is a proud one, marked with brilliant accomplishments and leadership. Ours have been some of the greatest advances that medical science has ever known. Not a few of these have been achieved in the Pacific area. It is at once an opportunity and a challenge.

The medical service of the Command has an enviable position, resulting from its efficient work. It is my hope that, working together, we may merit the continued good opinion of our military superiors.


EDGAR ERSKINE HUME
Major General
Chief Surgeon

RESTRICTED

GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER

APO 500

NUMBER. 8

1 August 1949

PART IADMINISTRATIVE

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I. Organization of the Medical Section

Departure from the Medical Section, General Headquarters, Far East Command: Major General James A. Bethea, MC Chief Surgeon, completed his tour of duty and has departed for Brooke General Hospital, Fort Sam Houston, Texas.

Arrival in the Medical Section, General Headquarters, Far East Command: Major General Edgar Erskine Hume, formerly Chief Reorientation Branch, General Staff, Department of the Army, has assumed the duties of Chief Surgeon, Far East Command.

II. Clarification - "Some New Therapeutic Agents"

In the article "Some New Therapeutic Agents," Section XXII, of the Surgeon's Circular Letter, 1 May 1949, Nikethamide, Colchicine, and Diphtheria and Tetanus Toxoids, Alum precipitated combined with pertusis vaccine were inadvertently listed as being standard items available for issue through Army and Air Force medical supply facilities. At that time all three of these items were listed in the Army-Navy Catalog of Medical Materiel as "Navy only", and were obtainable by Army and Air Force medical installations only as non-standard items. Nikethamide and Colchicine still remain in this category and can be obtained only on non-standard requisition. Diphtheria and Tetanus Toxoids, Alum precipitated combined with pertusis vaccine became available for Army and Air Force issue with the recent receipt of Change Bulletin No. 4, Army-Navy Catalog of Medical Materiel dated April 1949 which eliminates the "Navy only" restriction on issue of this item.

III. Resume of Medical Department Officers, FEC, Requesting Assignment to DAF

In connection with current planning for the establishment of an Air Force Medical Department the following numbers of Medical Department officers on duty in the Far East Command have indicated desire for assignment to the Department of the Air Force (*indicates officers at present

serving with FEAF):

MEDICAL CORPS

<u>GRADE</u>	<u>RA</u>	<u>NON-RA</u>	<u>TOTAL FEC</u>
Brig Gen	-	-	1
Col	3*	-	26
Lt Col	2	-	27
Lt Col	5*	2*	
Major	4	-	24
Major	2*	1*	
Capt	1	4	100
Capt	2*	17	
1st Lt	-	5	154
1st Lt	-	5*	

DENTAL CORPS

<u>GRADE</u>	<u>RA</u>	<u>NON-RA</u>	<u>TOTAL FEC</u>
Col	-	1	
Col	2*	-	9
Lt Col	3	-	
Lt Col	5*	3*	34
Major	2	2	
Major	5*	6*	48
Capt	5	3	
Capt	2*	2*	34
1st Lt	-	4*	11

VETERINARY CORPS

<u>GRADE</u>	<u>RA</u>	<u>NON-RA</u>	<u>TOTAL FEC</u>
Col	-	-	2
Lt Col	-	-	2
Major	-	2	
Major	2*	1*	16
Capt	-	-	9

MEDICAL SERVICE CORPS

<u>GRADE</u>	<u>RA</u>	<u>NON-RA</u>	<u>TOTAL FEC</u>
Col	-	-	2
Lt Col	1	-	
Lt Col	-	1*	14
Major	5	6	
Major	1*	3*	72
Capt	4	30	
Capt	4*	18*	218
1st Lt	1	28	
1st Lt	2*	10*	153
2nd Lt	-	1	
2nd Lt	-	2*	7

ARMY NURSE CORPS

<u>GRADE</u>	<u>RA</u>	<u>NON-RA</u>	<u>TOTAL FEC</u>
Lt Col	-	-	1
Major	1	1	9
Capt	16	21	
Capt	2*	3*	128
1st Lt	19	75	
1st Lt	3*	3*	346
2nd Lt	-	1	10
WOJG	-	2	

WOMEN'S MEDICAL SPECIALIST CORPS

<u>GRADE</u>	<u>RA</u>	<u>NON-RA</u>	<u>TOTAL FEC</u>
Major	-	-	2
Capt	3	1	5
1st Lt	1	1	16
2nd Lt	-	-	1

IV. Officers - Retention on Extended Active DutyEvaluation of category statements:

a. All officers who are qualified and who desire extended active duty upon the expiration date of current category must submit applications for new category not earlier than 7 months nor later than 6 months prior to expiration of current category in accordance with the provisions of SR 135-215-5, dated 27 May 1949.

b. Officers promoted subsequent to the 6 months' period and prior to separation may apply for a new category. Officers who do not qualify for a new category and who do not desire extension of active duty will be separated upon expiration of their current tours.

c. An officer serving in an overseas command whose current category will expire prior to completion of prescribed overseas tour must apply for a new category or be returned to the ZI in time for separation upon expiration of his current category. Qualified officers with dependents may be retained overseas for completion of service required subsequent to arrival of dependents in the overseas command, even though a new statement is not signed.

Enlistment in Grade 1:

a. Under the provisions of the same Special Regulation the guarantee that each officer who was on active duty on 22 March 1948 would be given an opportunity to enlist in Grade 1 will expire upon expiration of current category. Upon expiration of this category or upon separation prior to expiration the officer concerned must enlist the day following separation in order to be eligible for Grade 1.

b. If the officer is separated and does not enlist the day following separation, and if he applies for and accepts a new category extending him on active duty as an officer, enlistment at a later date will be in such grade as is provided for in current directives. This does not affect the eligibility of officers who hold permanent warrant in Grade 1 to return to that grade at any future date.

V. Medical Services Organization of National Military Establishment



Secretary of Defense Louis A. Johnson has announced that Dr. Raymond B. Allen, President of the University of Washington, Seattle, has accepted the job of organizing the medical services of the National Military Establishment and Dr. Richard L. Meiling, of the College of Medicine, Ohio State University, has been selected as Director of Medical Services, effective 1 October 1949.

Dr. Allen and Dr. Meiling will assume their duties about 1 July. Dr. Allen will act as Director of Medical Services until 1 October when he will return to the University of Washington, but will resume his membership on the NME Armed Forces Medical Advisory Committee, of which he was one of the original members.

Dr. Meiling will serve as Deputy Director of Medical Services until 1 October and will assist Dr. Allen in organizing the NME Medical Services Divisions, as well as in coordinating the operations of the medical services of the three military departments and related NME agencies.

(ED's NOTE: See Section VI, page 2, "Establishment of the Medical Services Division", S.C.L. No. 7, 1 July 1949.)

VI. Three MSC Officers Named as Assistant Chiefs to Head Three Major Sections of the Medical Service Corps

Former Director, Supply and Fiscal Division, Medical Section, GHQ, FEC, Major John V. Painter, MSC, was appointed as assistant chief of the Pharmacy, Administration and Supply Section, one of the three major sections of the Medical Service Corps. Major Painter served in the Far East Command from October 1945 to September 1948.

The other two new assistant chiefs are Lt. Colonel Charles S. Gersoni, MSC, formerly executive officer to the European theater adjutant general who will head the Medical Allied Sciences Section; and Major Raymond J. Karpen, MSC, who served as chief sanitary engineer for the Ninth Air Force during the invasion of Europe, will head the Sanitary Engineering Section.

VII. Army Begins Joint Staffing of Naval Hospitals

Joint staffing of four Naval hospitals with Army medical personnel at St. Alban's Hospital, Long Island, New York; Corona and Long Beach Hospitals, California; and Portsmouth Hospital, Portsmouth, Virginia, was recently announced.

The joint staffing of military hospitals was recommended by the Hawley Board in January of this year in order to economize to the fullest extent possible on physicians and other scarce professional personnel and to reduce the number of hospitals. Under the plan, hospitals of the respective services allocate a certain number of beds for patients from other services. A total of 825 beds has thus been made available in these four hospitals for Army and Air Force patients.

Nine Army Medical Corps officers, including a pediatrician, an internist, a general surgeon, an orthopedic surgeon, and five general duty physicians, are being assigned to St. Alban's Hospital,

which has allocated 450 beds to Army and Air Force patients. Allocation of these beds made it possible for the Army to close Fort Totten General Hospital, Long Island, and to reduce Tilton General Hospital, Fort Dix, New Jersey, to station hospital status, effective 30 June.

At Corona and Long Beach Hospitals, a total of 300 beds have been turned over to the Army and Air Force, making it possible to close McCornack General Hospital by 30 June. An internist, a general surgeon, and a general duty physician are being assigned to each of these hospitals by the Army Medical Department.

Members of the Dental Corps, Army Nurse Corps, Medical Service Corps, and Women's Specialist Corps and enlisted personnel are being assigned to these hospitals in proportionate numbers to help with the workload of all patients and augment the hospital staff.

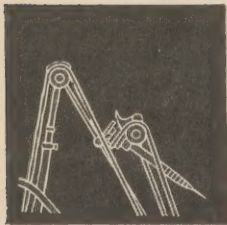
In a similar joint staffing procedure, the Navy recently assigned personnel for duty at the Army's Tripler General Hospital at Honolulu, Hawaii, where all Naval patients in the Islands are now hospitalized.

VIII. Another Hospital Joins Intern Program

The Army has opened Valley Forge General Hospital, Phoenixville, Pa., to the graduate professional education program. Effective 1 July, this additional general hospital will provide a new source of training to young physicians interested in the Army military intern program.

The military intern program, which provides for 300 internships annually, offers graduate professional training opportunities at Army general hospitals to selected graduates of medical schools. Students are given the opportunity to apply for Regular Army Medical Corps commissions at the end of their internships.

IX. Dental Students Selected for Army Dental Intern Program



Fifty students who will graduate this year from civilian dental schools, chosen on the basis of scholastic attainment, physical fitness and aptitude for military service, have been selected for the Army Dental Intern Program. These interns will be tendered commissions as first lieutenants in the Dental Corps Reserve after graduation and will be ordered to active duty for assignment on 1 August to one of the Army general hospitals where the teaching program is carried on.

The internships are of the rotating type, including instruction in oral diagnosis, operative dentistry, oral surgery, prosthetics and periodontia. General hospitals at which internships are offered are: Brooke, Fort Sam Houston, Tex.; Fitzsimons, Denver, Colo.; Letterman, San Francisco, Calif.; Madigan, Tacoma, Wash.; Oliver, Augusta, Ga.; Percy Jones, Battle Creek, Mich.; Valley Forge, Phoenixville, Pa.; and Walter Reed, Washington, D.C.

X. Army Hospital Course

A fourth class in Hospital Administration, starting 8 August 49 and ending 23 December 49, was recently announced by the Army Surgeon General's Office. The course will be of 20 weeks duration and will be conducted at the Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Texas. Reporting date will be 3 August.

XI. National Guard Offers Commission to Medical Officers

The National Guard is offering commissions to 1949 graduates of medical and dental colleges who are not enrolled in ROTC medical or dental units.

General Kenneth F. Cramer, National Guard Bureau, announced that men graduating this

summer from accredited medical and dental schools, and beginning to serve their internships, may be commissioned immediately as first lieutenants in the Guard without previous military service. Those who served as commissioned officers during World War II may receive commissions one grade higher than normally called for by the unit vacancy to which they would be assigned, if they served in the higher grade during the war.

Like the regular services, the Guard needs doctors and dentists. Under current requirements, about 1,200 vacancies exist in Army and Air Guard units in grades ranging from first lieutenant to colonel.

Doctors and dentists are especially needed in time for service during the coming field training which will involve about 5,000 Guard units and 300,000 men.

XII. Medical Follow-Up Card

Medical officers from station hospitals, dispensaries and troop assignments throughout the Far East Command now have available a Medical Follow-Up Card. Information concerning the findings and recommendations concerning patients who have been evacuated to hospitals of higher echelons can now be received through this means. The card can also be used as a method of obtaining satisfactory follow-up report on interesting cases that are evacuated to the ZI.

Procedures for the initiation, completion and further handling of the Medical Follow-Up Card are given in SR 40-590-60-AFR 160-47.

MODEL

PATIENT (Last name - First name - Middle initial)
CONDITION ON ARRIVAL AT HOSPITAL

DIAGNOSIS

SUBSEQUENT THERAPY AND PROGRESS

GRADE

SERVICE NO.

REPORTS CONTROL SYMBOL MED-51

DISPOSITION ☐ PROBABLE ☐ FINAL

REMARKS OR RECOMMENDATIONS

DATE

SIGNATURE AND GRADE

HOSPITAL

SERVICE

To be completed and returned to the inquiring Medical Officer after definite conclusions have been reached as to diagnosis, therapy, and disposition, or at the expiration of 60 days. When mailing, use window envelope.

NME FORM 1 APR 49 183

MEDICAL FOLLOW-UP CARD

10-58430-1

INSTRUCTIONS.—This card is designed to enable Medical Officers to follow the clinical course of transferred patients in cases of unusual professional interest; use of card is optional. Write your own name, grade, and service on this side of card (FOR); together with the name or number and location of your hospital. Fill out name, grade, and service number of patient, on reverse side of card. The remaining data will be supplied after arrival of patient at hospital to which transferred.

HOSPITAL

TO: COMMANDING OFFICER.

STA OR APO NO.—CITY OR TOWN—ZONE NO.—STATE

FOR:

U. S. GOVERNMENT PRINTING OFFICE 10-58430-1

XIII. Publications and Blank Forms

Requests for blank forms and publications have been made on the Medical Section, GHQ, by personnel of every echelon of medical service in the Far East Command. This Section is authorized to requisition and stock only those forms and publications required for the administration of the Medical Section, GHQ. The Adjutant General's Department is the responsible agency for supply of publications and blank forms.

Attention is invited to the model copy of WD AGO Form 17, 1 June 45, and reverse side, reproduced below. Compliance with instructions in the preparation of this form by all agencies responsible for requisitioning publications and blank forms will insure receipt of an adequate supply. However, in cases of non-receipt, follow-up action should be taken to the source of supply to determine the reasons therefor.

OVERSE

REQUISITION FOR PUBLICATIONS AND BLANK FORMS

FORWARD IN DUPLICATE. READ INSTRUCTIONS ON REVERSE SIDE

CHECK ONE
1. ☐ REGULAR
2. ☐ SPECIAL
3. REASON FOR SPECIAL REQUISITION
4. DATE
5. STATION NO.
7. SHIP TO

LINE ITEM NO.	NOMENCLATURE	CONTROL LEVEL QUANTITY				ACTION BY DEPOT				REMARKS
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WD AGO FORM 17, 1 JUN 45. PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE.

REVERSE

GENERAL INSTRUCTIONS FOR ORDERING PUBLICATIONS AND BLANK FORMS

Complete and accurate preparation of this form will expedite processing of the requisition and shipment of publications and blank forms from the Adjutant General's depot, or other source of supply, and will eliminate unnecessary follow-up and correspondence. The requisition is to be authenticated by the commanding officer of the headquarters originating the requisition. Read carefully the following instructions:

1. This form will be prepared in triplicate. One copy will be retained by the originating headquarters; the original and duplicate will be submitted to the source of supply, and one of these copies will be returned to the originating headquarters indicating action taken thereon.

2. Prior to submission of requisitions, the appropriate publication indicated herein will be checked to assure accuracy of nomenclature of publication or blank form required, authorized use, and authorized allowances: AR 310-200, AR 1-16, and FM 21-6.

3. A separate requisition will be prepared and submitted for each category of publications and blank forms, for example, Field Manuals, Technical Manuals, Army Regulations, War Department Circulars, WD AGO blank forms, Standard blank forms, War Department blank forms, etc.

4. A separate requisition will be prepared and submitted for classified and accountable publications and blank forms.

5. Arrange items in numerical sequence within each category.

6. If changes to basic publications are desired, such changes will be indicated on a separate line.

7. Page numbers will be entered at the bottom of the requisition.

8. Items requisitioned and placed on back order will be canceled at the expiration of 60 days if stock remains unavailable at that time.

9. If items indicated as shipped are not received within a reasonable time, allowing for method of shipment, notify depot.

10. If copy of requisition, indicating action taken by depot, is not received within 15 days, notify depot.

INSTRUCTIONS FOR PREPARATION OF REQUISITION

(Paragraph numbers correspond to item numbers on face of requisition.)

1. Check as "regular," requisitions submitted in accordance with prescribed requisitioning date schedule.

2. Check as "special," requisitions for unusual requirements, requirements for alerted units (POM), for schools and training centers for instructional purposes, for newly activated units and when stock of an item is nearly exhausted.

3. Indicate reason for submitting special requisition; for example, "Newly activated unit" or "POM."

4. Enter date of preparation of requisition.

5. Enter the station number of the headquarters originating the requisition.

6. Enter the name of the depot, or other source of supply, to which requisitions for publications and blank forms will be forwarded.

7. Enter the name and complete address of the headquarters to which shipment is to be made.

(Paragraph numbers correspond to column numbers on face of requisition.)

2. Enter the numerical designation (or title, if unnumbered) of the item required. (Use a separate line for each item.)

3. Enter the unit, on blank forms only, such as "pad," "book," "cut sheet."

4. Enter quantity used the last 2 months.

5. Enter quantity on hand on date requisition is prepared.

6. Enter quantity required for maintenance of authorized stock level, consideration being given to projected increase or decrease which might be necessary.

Do not enter in columns 7 through 11. These columns are for use of the depot, or other source of supply, to indicate action taken on the requisition.

GENERAL INSTRUCTIONS FOR INDICATING ACTION TAKEN BY DEPOT

(Paragraph numbers correspond to column numbers on face of requisition.)

7. Items partially or completely shipped will be indicated by a check mark in column 7. If partial shipment is made, actual quantity shipped will be indicated in column 11, under "Remarks."

8. Items partially or completely unavailable and which are placed on back order will be indicated by a check mark in column 8.

9. Items partially or completely extracted to other sources of supply will be indicated by a check mark in column 9. The name of the agency to which extract was forwarded will be indicated in column 11, under "Remarks."

10. Items canceled will be indicated by a check mark in column 10. The reason for cancellation of an item will be indicated in column 11, under "Remarks." Cancellation will be made for any of the following reasons:

(a) Item cannot be identified. The requisitioning headquarters should take further action to identify the item required, preferably by forwarding a copy of the item, or reference to directive governing its use, to the depot.

(b) Items which have been declared obsolete, rescinded, superseded, or suspended.

(c) Items which are under revision, and for which current stock is not available.

(d) Items which are new but not yet published.

(e) Items which will be issued by the depot on initial distribution, upon availability of stock.

(Paragraph numbers correspond to item numbers on face of requisition.)

9. Enter date of shipment of available stock.

10. Indicate by check mark the method of shipment.

11. Enter the number of cartons, bags, or skids comprising the shipment made on the requisition.

12. Enter the bill of lading number, if shipment is made by commercial carrier.

13. Enter the registry number, if shipment is made by registered mail.

14. Enter the date and initials of personnel responsible for receiving, editing, filing, checking, and completing action on the requisition. (The date of completion will be the date on which the action copy of the requisition is forwarded to the headquarters originating the requisition.) The action copy of the requisition will be forwarded to reach the originating headquarters prior to the receipt of stock.

The requisition number assigned by the depot will be entered at the bottom of the requisition.

XIV. Report of Sick and Wounded Animals

Attention is invited to Department of the Army, SR 40-985-5, Medical Service, Records and Reports of Sick and Wounded Animals, dated 19 April 49. These regulations supersede AR 40-2245, 12 October 42; paragraph 9, AR 40-2235, 27 November 42, and paragraph 3 h, Section IV, WD Circular 189, 1947.

XV. Recent Department of the Army and FEC Publications

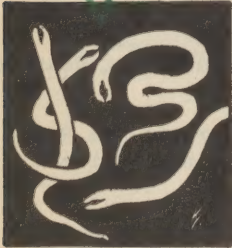
- AR 605-600, 19 May 49 - Officers: Demotion and Elimination. Par 4. Reasons for Demotion, Separation, or Elimination. Sub Par b (3) and (4). Par 6. General Board Procedures. Sub Par d and e
- AR 40-210, 23 May 49 - C-10. Prevention and Control of Communicable Diseases of Man. Pars 10 and 23 Changed
- AR 600-37, 27 May 49 - C-8. Personnel: Prescribed Service Uniform - Women Personnel of the Army
- AR 350-1010, 8 Jun 49 - C-1. Professional Education and Training for Medical Department Officers. Par 3
- AR 40-100, 13 Jun 49 - C-6. Miscellaneous Physical Examinations. Par 1 c Superseded
- AR 40-705, 16 Jun 49 - Medical Service: Physical Medicine
- DA CIR 79, 1 Jun 49 - Sec IV. Hospitalization and Medical Care; Sec XII. WD AGO Form 66. - Hospital Administrative Assistant Career Warrant Changed to Medical Administrative Assistant
- DA CIR 86, 21 Jun 49 - Army-Navy Catalog of Medical Materiel. Rescinds Sec IV, DA Cir 216, 1948
- DA MEMO 600-750-34, 1 Jun 49 - C-1. Enlistment and Assignment of Partially Disabled Combat-Wounded Veterans of World War II
- DA PAMPHLET 20-25, 8 Jun 49 - C-1. Career Guidance: Appointment of Warrant Officers to the Regular Army and the USAF. Hospital Administrative Assistant Changed to Medical Administrative Assistant with new job description.
- Army-Navy Catalog of Medical Materiel, Apr 49 - Change Bulletin No. 4
- Army-Navy Catalog of Medical Materiel, Jun 49 - Spare Parts Section 3-095-100. Basal Metabolism Apparatus
- SR 730-20-5, 8 Apr 49 - Oversea Supply: Oversea Command Forecast of Requirements. Supersedes DA Memo 700-10-18, 11 Mar 48 and Changes
- SR 605-240-1, 19 May 49 - Officers: Physical Evaluation; Hospitalization; Disposition. Supersedes: WD Cir 139, 46, Sec IV; WD Cir 303, 46 and DA Cir 296, 48
- SR 40-590-50, 20 May 49 - Medical Service: Donations of Cigarettes to Hospitals. These Regulations supersede SR 40-590-50, 16 Feb 49
- SR 135-215-5, 27 May 49 - Civilian Components: Officers' Voluntary Category Statements for Retention of Extended Active Duty
- SR 40-220-5, 6 Jun 49 - Medical Service: Army Federal Civilian Employees' Health Service Programs
- SR 600-440-1, 7 Jun 49 - Personnel: Disposition of Psychotic. Supersedes AR 600-500, 46
- SR 605-225-1, 7 Jun 49 - Officers: For Appointment or Reappointment as Warrant Officers or Enlistment or Reenlistment in Regular Army. Par 4. Physical Examination
- SR 600-37-1, 13 Jun 49 - Personnel: Women's Army Uniform
- SR 40-10-5, 16 Jun 49 - Medical Service: Utilization of Personnel and Treatment Facilities
- SR 40-1025-2, Jun 49 - Medical Service: Nomenclature and Method of Recording Psychiatric Conditions. These Regulations supersede Par 18, TB MED 203, 1945
- SR 30-2210-50, 17 Jun 49 - C-1. Food Service. Field Rations
- TB MED 114, 26 May 49 - C-1. Immunization. Par 6 b and Par 7 b, c and d, changed
- SB 38-4-MED, 17 May 49 - Replacement Factors and Consumption Rates. Medical Department. Supersedes SB 38-4-MED, 31 Mar 48

PART II

TECHNICAL

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Bleeding in Pregnancy.	XVIII	11
Use of the Male Philippine Frog, RANA VITTIGERA, as a Test Animal for Diagnosis of Early Pregnancy.	XIX	13
Traumatic Injuries of the Urinary Tract.	XX	14
Fat Content Reconstituted Milk	XXI	18
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XVI. Case Report - Massive Infestation with Hookworm following a Single Exposure, - Colonel Robert E. Blount, MC, Medical Consultant, GHQ, FEC



This 14-year old white male was admitted to an Army hospital on 10 July with asthmatic breathing, hoarseness, slight fever, and dermatitis on the lower half of his body. Intense itching first appeared on 4 July after surf fishing on a Japanese beach. He had spent most of the day with his father and a friend on a beach near Chiba. All three waded into the surf repeatedly during the day. The son was wearing blue jean trousers and leather shoes. When his father was later questioned it was found that the patient had waded into a little stagnant stream which emptied into the bay, to fish. Immediately upon emerging from the water the patient noted a severe itching over the lower half of his body. The father examined the boy's skin and found the lower half of his trunk and lower half of his extremities covered with small, 1-mm size, purple macules suggestive of minute insect bites. The itching persisted for approximately 10 days. About the 7th of July symptoms suggestive of an acute upper respiratory infection appeared, associated with low grade fever. A slightly sore throat and a scant, non-productive cough was noted. The sore throat persisted for a full week, although no objective evidence of inflammation was noted. The patient stated that he felt as if mucus were there that he could not bring up. Swallowing was painful. A laryngoscopy on the 14th of July revealed the larynx to be slightly edematous. Some difficulty in breathing was first noted about the 10th of July and on admission definite sibilant, asthmatic rales were noted, and the expiratory phase was prolonged. The white blood count on admission was 11,000, with 70% neutrophils and 30% lymphocytes. Hb 13 grams. No eosinophilia was reported, though we are reasonably sure that an eosinophilia was present. The dermatitis gradually cleared and the respiratory symptoms gradually disappeared and he was discharged from the hospital on the 29th of July, 1948.

During the succeeding ten days the child developed an unaccountable weariness. He was readmitted to the hospital on 6 August with some epigastric discomfort, vomiting, diarrhea, and fever. Diarrheal stools were noted to be black and were positive for occult blood. By the 7th of August an eosinophilia of 19% had developed. Repeated stool examinations for parasites and ova were negative and stool cultures were negative for pathogens. The ward surgeon elicited the history of repeated episodes of nausea and vomiting on several occasions in the past without any demonstrable cause. Proctoscopy and barium enema were not revealing. An interview with a psychiatrist revealed phobias for darkness and some evidence of immaturity for his age. This, plus the fact that he was the only child of over-protective parents, led him to feel that there was considerable "psychogenic overlay" in the problem.

Diarrhea continued and weight loss was progressive. He was discharged from the hospital on the 18th of August and remained at home for another ten days. Loose, watery stools, six to eight per day, continued and on the 28th of August he was hospitalized at another Army hospital.

By this time his weight had dropped from 145 to 110 pounds. Anorexia, malaise, and a sensation of weariness were very marked. About six to eight loose, dark, watery stools were occurring each day. Epigastric pain was still present. His mucous membranes were exceedingly pale. BP 108/74. Abdomen was soft and scaphoid. Neither liver or spleen were palpable. On 28 August stool specimen showed hookworm ova and innumerable red blood cells. The stool was almost black in color. Urine was negative. RBC, 3.4 million, with 8.5 grams Hb (59%). WBC, 19,450, with 68% neutrophils, 12 lymphocytes, 1 monocyte, and 17 eosinophils; hematocrit, 29; plasma protein, 5.1 grams; albumin, 3.2 grams, globulin, 1.9 grams; A/G ratio, 1.7. Erythrocyte fragility was normal. On 2 September, WBC was 17,700, with 32% eosinophils.

On 31 August he was treated with crystalline hexylresorcinol, 1 gram. On 2 September, following a saline purge, he was given 3 cc. of tetrachloroethylene followed by another saline purge. No actual worm count was made but many adult hookworms were passed. Specimens submitted to Lt. Col. George Hunter III of the 406th Medical General Laboratory, Tokyo, were identified as *Ancylostoma duodenale*.

The patient's symptoms continued unabated and weight loss continued so that on the 9th of September he weighed 99 pounds. By the 18th of September his weight had dropped to 97 pounds. By the 9th of September his red cell count was 2.86 million with 8.4 Hb; WBC 16,450, with 58% eosinophils. The chest was entirely clear. Repeated studies failed to show *Endamoeba histolytica*. Stool cultures were negative for pathogens. By 14 September the WBC was 17,700 with 60% eosinophils; RBC was 3.1 million with 8.7 grams (60%) Hb. By 20 September RBC was 3.4 million with 9.2 grams Hb; WBC was 18,550 with 64% eosinophils. He had been placed on ferrous sulfate, grams 10, p.c., on 4 September. On 16 September therapy with 3 cc. tetrachloroethylene was repeated. On 14 September feces was negative for hookworm ova for the first time, but subsequent hookworm ova were frequently found in the stools for several weeks. By the 27th of September RBC was 4.0 million with 8.7 grams (60%) Hb; WBC 13,950 with 50% eosinophils. By the 30th of September RBC was 4.2 million with 12 grams (83%) Hb; WBC was 9,700 with 53% eosinophils. Hematocrit was 44. By the 4th of October RBC was 4.1 million with 70% Hb and 48% eosinophils. On the 7th of October RBC was 4.4 million with 11.9 grams (82%) Hb; WBC was 19,750 with 46% eosinophils. By the 21st of September he began to gain weight and his appetite became voracious. He continued to steadily gain weight and strength and by the 11th of January, 1949, weighed 129 pounds. Eosinophils 28%, Hb 11 grams. Additional courses of hexylresorcinol and of tetrachloroethylene had been given. The stools were again positive for hookworm ova in March, 1949.

Discussion: This case illustrates a near fatal infestation with hookworm following a single day's exposure. The dermatitis developed immediately. The larval phase of the illness was manifested by a sore throat, excessive weariness, epigastric pain, bronchitis and bronchial asthma, diarrhea, eosinophilic leukocytosis, and irregular fever. Ova were first found in the feces on the 55th day. Intestinal bleeding appeared at least by the 33rd day. Anemia and loss of weight and strength were marked. The patient regained weight and strength very slowly and is still pale after nine months. The eosinophilia still persists. His stool was occasionally still positive for hookworm ova. Further exposure to hookworm infestation has not been likely.

The skin was described as appearing "flea bitten". These small purplish macules then became slightly raised and developed into vesicles which, upon being excoriated became secondarily infected. The bronchitis and asthmatic wheezing were probably based on an allergic reaction to the larva which were passed to the pulmonary capillaries. An eosinophilia of 19% had developed at this time. The diarrhea did not appear until approximately 30 days after the initial exposure. Anemia and hypoproteinemia developed about 30 days after the initial infestation. The first positive stool was noted on the 28th of August, which was exactly 55 days after the first exposure. No other causes for the diarrhea could be found. This diarrhea was rather unusually severe for hookworm infestation.

That massive infestation from brief exposure can lead to overwhelmingly severe, acute hookworm disease was emphasized by Col. Bailey K. Ashford.¹ The Puerto Rico Anemia Commission's report describes such a case in a negro, a race supposedly relatively immune. After working for sixteen days burying the feces of heavily infested patients he developed a marked hookworm dermatitis on both feet, followed by extreme asthenia and severe gastralgia. Intestinal bleeding developed and the patient barely survived.

Five of seven persons who bathed on a beach on 23 June 1932, after a tropical rain had caused a small stagnant, polluted stream to spill over onto the sandy beach, quickly developed intense, generalized pruritis that persisted for a week. They then felt as if they had caught cold, and some fever developed. Throats became sore and swallowing was painful. After another week marked asthenia was noted, soon to be accompanied by severe epigastric discomfort, then diarrhea. The stools soon were noted to be either tarry or to contain red blood. A marked eosinophilic leukocytosis developed. The most seriously ill of the patients had been in robust good health in early June. Col. Ashford² made a diagnosis of hookworm disease in spite of the absence of ova in the stools. The first and most severe case showed ova in fecal specimen one week later (48th day after exposure). This patient almost died from intestinal bleeding. Erythrocytes dropped to 1,256,000 with 15% hemoglobin. A leukocytosis of 36,200 with 14% eosinophils occurred. Later, after anthelmintic therapy, the WBC dropped to 17,800 but the eosinophils rose to 78%. This patient required eight courses of anthelmintics. A total of 1439 adult worms were eliminated. The parasite in these cases was *Ancylostoma duodenale*, the old world hookworm. Even after a year of good food,

plus iron, their hemoglobin values never exceeded 75% and all of this group were still pale though asymptomatic. The first case still showed an eosinophilia of 20%.

Ashford points out that obviously many larvae remain as wanderers in the body tissues until they die. He thinks the eosinophilia is largely a result of either living or dead larvae in the tissues. This larval phase is accompanied by loss of strength and weight, irregular fever, definitely high eosinophilia, and leukocytosis. Diarrhea occurs in severe cases.

Sai Ryo³ placed 300 Ancylostoma larvae on the skin of three volunteers. Eggs were found in their feces on the 54th, 55th and 57th days. He estimated that in each instance between 290 and 295 of the larvae penetrated the skin. After therapy he recovered adult worms numbering 77, 78 and 83, respectively. An eosinophilia appeared on the third day, reached its height in the sixth and seventh weeks, then diminished after the 15th week. The cutaneous lesions produced must be distinguished from those produced by cercariae of certain Schistosomas. The duration of the life of the adult parasite is not precisely known but is estimated to be between a few months and six years. Though infestation normally occurs when the skin is penetrated by filariform larvae, these larvae are infective when swallowed. As a rule it is felt that in the average case at least an adult worm burden of 500 for several months is required to cause severe symptoms.

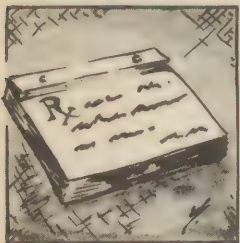
SUMMARY: A case is reported of overwhelming infestation with hookworm following a single exposure. The larval phase of massive hookworm infestation is frequently accompanied by sore throat, excessive fatigue, epigastric pain, bronchitis, bronchial asthma, diarrhea, eosinophilic leukocytosis, irregular fever, and loss of weight.

1. ASHFORD, B. K., King, W. W. and Guiterez, Pedro: Report of The Commission for the Study and Treatment of Anemia in Puerto Rico. Bureau of Printing and Supplies, 1904, p. 112.

2. ASHFORD, B. K., Payne, G. C., and Payne, F. K. Acute Uncinaria from Massive Infestation and its Implications, JAMA 101:843 - 847, 1933.

3. SAI RYO, quoted by Strong, Richard P., page 1255, Stitt's Diagnosis, Prevention and Treatment of Tropical Diseases, Seventh Edition, 1944, The Blakiston Company.

XVII. Penicillin for Oral Prophylaxis of Venereal Disease - A Warning; Editorial Extracted from The Journal of the American Medical Association, 2 April 1949



In October 1948, Eagle reported the results of a study conducted in a Naval activity which showed that 100,000 to 250,000 units of penicillin by mouth, taken after exposure to venereal disease, would reduce the incidence of gonorrhea by 85% or more. Following the publication of this report came strong pressure for general adoption of this measure. A second study conducted in the Navy indicated that the prophylactic effect of orally administered penicillin on gonorrhea diminished fairly rapidly with the increase of time between exposure and ingestion of the penicillin. After an elapsed time averaging fifteen hours between exposure and prophylaxis, the efficacy of the measure apparently dropped to less than 50%.

The Navy does not contemplate general adoption of this prophylactic measure against venereal disease. First, the method will presumably not protect against chancroid, lymphogranuloma venereum or granuloma inguinale, diseases which are of importance in many areas of the world. The efficacy of the measure against syphilis is not known and can be determined in man only after long and careful studies involving hundreds of thousands of individual uses. A long time must elapse before the reliability of this procedure as prophylaxis against syphilis can be established. Estimates indicate that a cost of approximately \$75 per case of gonorrhea prevented at one of the Navy's largest prophylactic stations would have been incurred, had oral prophylaxis with 250,000 units of penicillin been added to standard Navy prophylaxis. This cost would of course diminish in proportion to the increased risk of contracting gonorrhea which exists in certain foreign ports, and the measure might approach economic justification in certain selected localities. The mass use of penicillin orally for prophylaxis of venereal disease will probably be adopted by the Navy, if at all, only for certain selected areas and periods when risk of contracting venereal disease in a particular group is abnormally high. The procedure will not of course be recommended as the sole prophylactic measure.

The use of penicillin orally by persons not in armed forces will be a matter for in-

dividual decision, if the tablets are made available over the counter. For those who do not use prophylactic measures or whose skill or knowledge are insufficient to use known effective measures properly, and possibly for women, this method offers for the time being a valuable protection to health. The method can be demonstrated to be economically unsound, since scores of tablets would be taken in order to prevent a single attack of gonorrhea in most American cities.

The measure presents a potential hazard of great magnitude to the venereal disease control programs of public health agencies. Some laboratory evidence indicates that the tendency of the gonococcus to become resistant to penicillin is much less than its tendency to become resistant to sulfonamide compounds. The resistance to penicillin is rather easily lost. After a failure of cure with a given dose, the same dose on a later day may sometimes effect a cure.

One reason that penicillin-resistant strains of gonococci have not become prevalent in this country is believed to be that the standard dose of penicillin used in treatment in this country is several times the minimal curative dose. Usually the dosages used will cure all but 1 or 2 per cent of the cases in the first course of treatment. This excessive dosage will kill off promptly almost all mutant strains that have developed only moderate resistance. Occasionally as much as 900,000 units of penicillin is needed to obtain a cure in gonorrhea.

Considering that blood levels obtained by oral administration of penicillin are only a small fraction of those obtained by the standard parenteral treatment for gonorrhea, the general adoption of oral prophylaxis against gonorrhea might eventuate in a large number of persons' harboring gonococci and receiving frequent subcurative doses of the antibiotic. This new situation would be ideal for production and propagation of resistant strains of gonococci. Although the possibility is as yet only a question, the general use of penicillin orally for the prophylaxis of gonorrhea might hasten the day when 1,000,000 units of penicillin will be required to cure an average case of gonorrhea.

XVIII Bleeding in Pregnancy - Presented by - Dudley R. Smith, MD, Instructor in Obstetrics and Gynecology, Washington University School of Medicine, St. Louis, Missouri. Notes taken by Capt. H. K. Miller, MC, 49th General Hospital, Tokyo, Japan



It has been suggested that I present for your consideration one of our serious complications associated with pregnancy. We have three good ones when we think of infection, toxemia and hemorrhage.

One, our bad one, is still infection. I have been waiting for a 4-5 year report, since we have had our better penicillin and streptomycin, to see if it would fall to the bottom.

Next are our toxemias of pregnancy. We want to consider nephritis, nephrosis, pre-eclampsia as well as eclampsia.

Then we have another one which presents itself often with an acute onset as you will find and that is hemorrhage in pregnancy. Accounting at the present time for approximately 60-70% of our mortality.

Our incomplete abortions without infection are first and the most common. I have never seen it kill anyone with treatment. Even in the presence of severe hemorrhage, they recover. Treat these conservatively if possible. If bleeding continues clean the uterus out. Rarely do you need to pack the uterus. If bleeding continues, curette with a blunt curette to remove any remains. Then pack the uterus for 24 hours. Rarely does packing need repeating.

Our second complication of importance is our extrauterine pregnancy and our tubal pregnancy is our primary consideration. The history generally consists of missing a menstrual period usually by two and certainly four weeks and onset of soreness in the lower abdomen on one or frequently both sides. The soreness increases in severity to actual pain. By the time the pain begins we have vaginal bleeding. Usually that much of a history is very significant of tubal pregnancy. It does not exclude P.I.D. Temperature, pulse, blood counts in addition to pelvic examination are necessary. Pelvic examination discloses a cervix that is tender to palpation and particularly with motion. Usually, lateral motion is of the most value. Very often in less tender patients a small mass may be felt. With a palpable mass and a history in the absence of infection diagnosis of a tubal pregnancy is 99% correct. A stoic individual not educated or interested in herself may neg-

lect to consult a physician and allow the pain to increase until the fallopian tube is badly distended and then one of several things may happen according to the location. If in the fimbriated end of the tube or the lateral third there occurs tubal abortion and bleeding. If in the middle portion it is liable to rupture into the broad ligament or free into the peritoneal cavity. If in the isthmus or the medial portion it is most likely to rupture into the peritoneal cavity. In this locality severe hemorrhage due to rupture of terminal branches of the uterine artery may be fatal in one hour. I have seen it and that is a severe emergency. If in doubt of diagnosis use cul-de-sac puncture. Using a trocar aspirate the space between the posterior cervix and rectum. If blood is obtained consider it 100% diagnostic of intra-abdominal hemorrhage from ruptured tubal pregnancy. However, I have found myself erring on two occasions in this. After the blood had been cleaned out of the abdomen and the tubes found normal, I found a ruptured corpus luteum bleeding from an opened artery. This is very rare and is still a surgical emergency. The tube with the ruptured tubal pregnancy and usually the ovary on that side will have to be removed. I'll not go into replacement of blood and plasma for I'm sure you all recognize that phase of therapy.

The next bad actor which I would like to consider is placenta previa. It may be very mild or it may be very severe. I would like to consider a pregnant woman in whom the placenta comes to the internal os of the cervix, or a marginal placenta. These ordinarily do not produce too much trouble for the mother or the baby. In those cases where the cervix is partially covered there may be a little more trouble for the mother and occasionally for the baby and may cause an obstruction in birth. The other is central placenta previa. The entire cervix is covered with placenta which also covers the lower uterine segment as well. Signs and symptoms consist of painless bleeding in the third trimester of pregnancy usually when the woman is asleep. I have never found anyone with a good explanation for this. The woman may have done her washing and other housework during the day and then at two or three o'clock in the morning awoken with the bed saturated with blood. Examination shows pregnancy and on vaginal examination some placental portion can usually be palpated. If you like try X-Ray visualization of the placenta over the cervix. Sometimes I think it worth while especially when the cervical os is closed and you can't feel the placenta.

Treatment is essentially the same. In the milder cases keep them relatively quiet and let them alone. A little margin in the cervix usually doesn't amount to much. Usually after a period of a few days or even a few hours they may go into spontaneous labor. If labor does not ensue and bleeding continues and if you are sure it is a mild type or marginal placenta then go ahead and rupture the membranes. Labor ensues in 12-24 hours or even 5-6 days. The head will then block the placenta and stop the bleeding. If it is a central placenta previa or if there is a reasonable belief that it is central then there is only one good treatment in a modern hospital and that is caesarian section. The type of section depends upon the operator. I would prefer the classical type. Many prominent surgeons insist that the low cervical is the most desirable because you can see the area of placenta attachment better and thus be able to stop any bleeding by running a few sutures through the area. I have had satisfactory results with the classical type. If you want to do a low cervical section no one will criticize you. I have criticized doctors, including myself, for doing sections but never for doing a caesarian section in placenta previa. As an oddity, I happened to have at my service at the hospital a multiparous woman deliver a living baby through a central placenta previa without hemorrhaging. The placenta was as big as the top of a 12 quart bucket. The central part implanted over the cervix was thinner than normal. This one however, is for Ripley. It is the exception rather than the rule. The best treatment is caesarian section. If the patient has been badly managed and has become infected, it may be better to do a hysterectomy at time of section even with penicillin and streptomycin.

We will now consider premature separation of the placenta and the uterus. Some call it abruptio placenta or uterine placental apoplexy. Actually it is a hemorrhage between the placenta and the uterus. The first symptom is usually slight vaginal bleeding which continues and increases. It is followed very quickly by pain and in many cases pain is felt first. It is a severe pain constant in character and does not subside. On examination you find the patient in any stage of pregnancy but usually in the third trimester. Instead of the usual soft uterus, you find it to be in a constant state of contraction, even to a board-like resistance. No fetal parts are palpable through it. Palpation is painful. With these findings you can make a diagnosis of uterine placental apoplexy. Occasionally, there is only pain and a hard uterus. In other words, the hemorrhage may be of the concealed type.

The abdomen must be opened and the baby delivered. The uterus is retained on its ability to relax and contract. You can disregard the amount of blackish discoloration of the uterus due to the intrauterine hemorrhage within the wall if it can relax and contract.

Another of our hemorrhages in pregnancy is ruptured uterus. It is primarily due to one of quite a few causes. Basically the first reason for ruptured uterus should be disproportion between the size of the baby and the pelvis as in a contracted pelvis. Secondly it may be due to an injured uterus and this may be any place from the cervix to the top of the fundus. Injury to the cervix may be due to a previous delivery especially to the instrumental type when the cervix is incompletely dilated so that the tear extended up the uterine wall up to the vessels. Therefore, in a subsequent pregnancy the resistance of the cervix produces extension of the original tear producing hemorrhage into the broad ligaments. Another uterine injury is previous caesarian section. All of us who do major surgery believe ourselves good in our own minds but I have never been able to determine 2-4 years later how good a scar you have got in that uterus no matter how good the original operation was. Even a good scar with a placenta attached across it will in the course of pregnancy be thinned down to the point where it can't withstand the strain of labor.

There is only one treatment. Open the abdomen and remove the baby and placenta. Determine the extent of the injury that has occurred to the uterus. If it is of a type that can be repaired then do so especially if the woman wants children. At times it is safer to remove the uterus quickly even leaving big hematomas in the broad ligament if they can't readily be aspirated.

I would like to caution you on the injudicious use of any toxic drugs, even Ergotrate. I have seen pituitrin produce severe enough contractions so that the uterus ruptured transversely across the anterior uterine wall. The other one thing I might mention is hemorrhage from the uterus associated with pregnancy and with carcinoma of the cervix. It is rare but it does occur.

XIX. Use of the Male Philippine Frog, RANA VITTIGERA, as a Test Animal for Diagnosis of Early Pregnancy, - Capt. Hugh L. Keegan, MSC, and Capt. Paul S. Stonesifer, MC, 3rd Med Gen Lab, APO 900



Use of male frogs and toads of several species as test animals for early pregnancy has been reported by Galli-Mainini (1, 2) and by Wiltberger and Miller (4). Studies at this laboratory indicate that males of the philippine frog, Rana vittigera (Wiegmann, 1836), may also be used for that purpose.

This frog, which is common on Luzon, has also been reported from the islands of Mindoro, Negros and Polillo by Taylor (3). It is similar in size, appearance and habits to the North American grass frog, Rana pipiens Schreber, which was used as a test animal by Wiltberger and Miller. The male of Rana vittigera is distinctly smaller than the female, and may easily be distinguished from the latter by presence of a dark blotch on either side of the throat. A series of 130 male specimens collected near Manila varied in body length from 51 mm. to 73 mm. Mean body length was 62.1 mm. Four female specimens from the same locality measured 87 mm, 87mm, 89mm, and 99 mm in body length. Color dorsally is usually olive gray with numerous, irregular, blackish spots on the body and limbs. Occasional specimens show a greenish tinge. Conspicuous are a prominent W-shaped blotch between the shoulders, and a light diagonal line extending from near the eye to the groin on either side of the body. Many specimens have a light mid-dorsal line extending from the snout to the anus. Some specimens possess a narrow, yellow line from knee to heel.

Technique employed closely follows that described by Wiltberger and Miller. Five cubic centimeters of a first morning specimen of test urine is injected subcutaneously into the dorsal lymph sack of each of two adult male frogs. Each frog is placed in a clean, dry beaker and set aside for 4-5 hours. At the end of this period any urine that has been voided by the frogs is examined microscopically for presence of spermatozoa. If this first sample of urine contains no spermatozoa, or if no urine has been voided, the frog is seized in the hand, or is taken from the container and gently prodded, after which treatment it will usually urinate. If no spermatozoa are present in either specimen of urine, the test is negative. If they are present, the test is positive. It is important that a second specimen of urine be obtained, if the first sample is negative. In many instances the urine found in the container was negative, and the fresh sample positive. In several cases the frog was held overnight, and the test determined to be positive upon examination of urine voided nearly 24 hours after the original injection. Frogs dessicate rapidly in a dry environment, and it was found that urine samples were more easily obtained, if the test animals were kept in moist chambers throughout the waiting period.

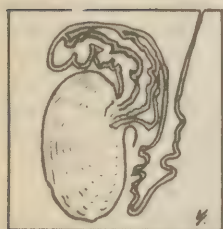
Positive frog tests were obtained with 35 of 41 urines which gave positive results with

the Ascheim-Zondek, Friedmann, or rat pregnancy tests. On each of three of the false negative tests only one frog was used. Negative frog tests were obtained with 13 of 14 urines which gave negative results with Ascheim-Zondek, Friedmann, or rat pregnancy tests. The single case of disagreement proved to be a false negative Ascheim-Zondek test. All of 151 control frogs injected with urines of non-pregnant persons or with sterile saline produced negative urines. Quantitative tests were run with five urines. Of these four were positive in dilutions of 1:100, and one was positive in a dilution of 1:50. Two of three urines of patients with choriocarcinoma gave positive results with the frog test. One of four frogs receiving injections of loc of oil containing 10,000 international units of estrone gave positive results. That test was made after it was found that urine of a patient in late pregnancy (the day before delivery) gave positive results.

Results indicate that the male of the philippine frog, *Rana vittigera* (Wiegmann, 1836), may be used as a test animal for diagnosis of early pregnancy. Although false negative tests occurred six times in a series of forty-one tests, three of these resulted when only one frog was used for the test. There were no false positive tests. The technique involved is simple, and, because frogs are cheap and easily obtainable, this test should be of practical value in the Philippine Islands and other portions of the Far East, where albino mice, rabbits, and rats are still scarce as a result of the war.

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 2. GALLI-MAININI, C. J. Amer. Med. Assoc., 1948, 138, 121-125
 3. TAYLOR, E. H. Amphibians and Turtles of the Philippine Islands, 1921.
 4. WILTBERGER, P. B., and MILLER, D. F. Science, 1948, 107, 198.

XX. Traumatic Injuries of the Urinary Tract presented by Dr. Richard Chute, Instructor in Genito-Urinary Surgery, Harvard Medical School, at the 49th General Hospital, Tokyo, Japan



First I will discuss injuries of the kidney. This well protected organ is most frequently injured in jeep accidents, or football and baseball injuries. There are several types; Contusions of the kidney in which a small amount of blood is lost, but there is no shock and there is no specific treatment necessary. A little more serious type of injury is a laceration of the kidney in which blood may be lost through the renal pelvis and in the perinephritic region. Next in importance is rupture of the kidney, in such a case as this passage of blood clots down the ureter may be extremely painful and stimulate the passage of ureteral calculus. Symptoms are hematuria, pain, tenderness, colic and a mass in the loins due to blood and urine which have escaped from the kidney. Diagnosis is made by the history of trauma, the presence of hematuria, physical examination showing pain and tenderness in the loin and possible mass. Intravenous pyelograms are of no value if the patient is in shock because the kidney will not excrete the dye, however, the patient may not be in good enough general physical condition to undergo a cystoscopy and retrograde examination. When this test can be performed there is extravasation of the dye into the kidney substance itself and lacerations of the kidney, and into the perinephritic space in case of a rupture of the kidney.

In regards to the treatment; the treatment for contusions and lacerations is expected and supportive with careful and frequent observations for any appearing trouble. A laceration of the cortex of the kidney may be sutured at the time of operation, if it is found. The treatment of rupture of the kidney is nephrectomy.

The following is a report of three cases from my private practice:

Case # 1: This boy was hit in the stomach while playing baseball. An intravenous pyelogram showed the dye was extravasated outside the calices. At surgery he was found to have a laceration of the kidney which was sutured. In one month he had a normal intravenous pyelogram.

Case # 2: This was a man who was hit by an automobile. Examination showed some

bruises over the abdomen and the presence of blood in the urine, but no shock. During the next few days he had the gradual onset of a mass and tenderness in the right flank; attempts at intravenous pyelography were of no value. Retrograde examinations showed extravasation of the dye outside the kidney shadow and at the time of surgery a laceration was found which was sutured. He had a normal intravenous pyelogram one month later.

Case # 3: This was a man who was in a jeep accident. Because of pain in one flank he had a retrograde pyelogram which showed the dye extravasated from the kidney shadow. At operation he had laceration which was sutured and one month later intravenous pyelograms showed a scar constricting the upper calyx.

Next I would like to discuss injuries of the urethra. These are frequent following attempts to dilate a stricture by a urologist. In a contusion of the urethra a small amount of blood in the urine is present and no action is called for.

At this time it would be well to review some of the anatomy of the pelvic floor; the triangular ligament separates the pelvis from the perineum; as a rule this also separates injuries and infections of the pelvis from those of the perineum. In severe injuries of the perineal urethra the patient cannot usually void and an instrument cannot usually be passed into the bladder. If the perineum is bulging it may be opened and the urethra resutured under direct vision and catheterized in this way. Suture of the urethra is rather difficult. If supra-pubic cystotomy is necessary pass the catheter down through the urethra for a splint and leave it in place. If the injury results in a tear of the membrane of the urethra a physical examination should show the prostate to ride up; that is, it is higher than the examining finger usually finds it. There is extravasation of urine in the prevesicle space, but there may also be some extravasation retro-peritoneally. The treatment of such a case is cystotomy to care for the urinary drainage, drainage of the extravasation of urine and the replacement of the prostate in its normal position. A Foley catheter can be inserted from the supra-pubic incision passed out through the urethra and about 30 c.c. of water injected into the bag. The catheter is then put on tension using about 2 lbs. with a pulley over the end of the bed and pulling the prostate down into normal position allowing the urethra to heal around it.

In rupture of the bladder extra-peritoneal extravasation of the urine is the commonest type, this is into the prevesicle space with physical findings of crepitation and swelling with complaints of pain by the patient. Intraperitoneal extravasation which may also occur is less common; this condition has a lot of pain associated with it and frequently the patient is in shock. He desires to void but cannot, later these patients get typical peritoneal signs and when they are catheterized only a small amount of urine is obtained. Treatment of both extra-peritoneal and intraperitoneal extravasation of urine is surgical exploration with drainage of the urine and suture of the laceration.

Following is a report of two cases of bladder rupture:

Case # 1: This was a patient who had a Hunner's ulcer in which the bladder was over distended by the introduction of silver nitrate by the Urologist, it ruptured and surgical exploration was necessary.

Case # 2: This was a patient who had a tumor of the rectum which was removed at surgery and following operation there was not adequate urinary drainage and the patient began to develop peritoneal signs. She had an injury to the bladder suffered during surgery and surgical exploration was carried out but the patient did not survive.

In summary there are five important points to make in regards to injuries of the urinary tract:

1. In suspected ruptured kidney a retrograde pyelogram is more reliable than an intravenous pyelogram.

2. The triangular ligament separates the pelvis from the perineum.
3. In urethral injuries be sure to put a catheter in as a splint and do a rectal examination to locate the prostate gland.
4. In cases of questionable rupture of the bladder be sure to instill an adequate amount of fluid for testing the rupture; by an adequate amount is meant several hundred cubic centimeters.
5. Be sure there are no undrained retroperitoneal extravasations of urine behind the bladder in cases of rupture. These are the most difficult to diagnose but are the most dangerous.

COMMENTS BY DR. CHUTE ON UROLOGICAL CASE HISTORIES:

Case # 1: The history of a four year old male with a perinephritic abscess was presented.

Comments by Dr. Chute: The diagnosis of early perinephritic abscess depends on a typical history of the presence of fever and the x-ray findings of a classical case, which are: (1) Obliteration of the psoas shadow on the affected side, (2) the kidney is fixed by inflammation, with no motion on inspiration and expiration film, and (3) scoliosis of the lumbar spine to the opposite side. All these findings are present in this case which is a typical one.

Case # 2: This patient was a 42 year old white female, a civilian dependent who was admitted with right flank pain of a constant nature for one week associated with spiking fever. A presumptive diagnosis of perinephritic abscess was made and intravenous pyelography showed the findings characteristic for such an abscess. The treatment in this case was penicillin; there was no surgical incision; however, several days after admission a large needle was placed in the perinephritic space and frank pus was aspirated which showed a pure culture of staphylococcus. The patient got along well with this treatment and her temperature came down to normal and her pain disappeared.

Comments by Dr. Chute: I do not feel that the conservative treatment is the correct procedure to follow. In such a case as this I would expect her to come to surgery within two weeks; however, she has been out of the hospital for 4 to 5 months now with no recurrence, this is an unusual situation. Pyelograms during the following 4 to 5 months as reviewed show much improvement in the condition and the patient is clinically well.

Question: What do you find the most common cause of perinephritic abscess?

Answer : Boils, but any suppurative process, such a simple one as a paronychia.

Question: How do you treat a solitary abscess of the kidney?

Answer : I think the best treatment is penicillin and surgical drainage. In the past this was called a carbuncle of the kidney.

Question: How do you treat multiple abscesses of the kidneys?

Answer : There are many factors in such a case, but I would probably do a nephrectomy.

Question: How do you differentiate between a paranephritic abscess and a perinephritic abscess?

Answer : I usually do not attempt to differentiate between them clinically; a paranephritic abscess is rare. The etiology of perinephritic abscess is bacteria in the tissues of the body which spread by means of the blood stream forming an abscess of the kidney which breaks through to the space between the renal capsule and Gerota's fascia. At surgery one should carefully examine the kidneys for such a condition.

Case # 3: This patient was a 19 year old white male soldier with a history of gradual onset of left flank pain which was persistent, and for this reason he was hospitalized with a questionable diagnosis of renal calculus. The x-ray films show a right hydronephrosis with suggestive U.P. obstruction. Would you comment on these films Dr. Chute.

Comments by Dr. Chute: This shows a typical generalized dilatation characteristic of hydronephrosis. First the pelvis is dilated, and in the second stage is dilatation of the calices; in the third stage is where everything dilates. Early tuberculosis is apt to hit one calix and start working on it and show a shaggy hydronephrotic type of pyelograph shadow in that area.

Question: What do you do when you find no reason for the hydronephrosis?

Answer : You keep looking until you do find a reason. Rarely can you tell more about the kidney by looking at it under direct vision of surgery than by x-ray examination, urine and cultures, except in the case of aberrant vessels of the U.P. junction.

Case # 4: This patient was a white male with constant hematuria for one week with occasional nocturia and frequency. Cystoscopy showed a normal bladder; the urine culture was negative; the x-rays showed a slight filling defect in the upper part of a bifid calix. Fluoroscopy showed this better and a diagnosis of papilloma of the pelvis was made. The patient was sent to the ZI for surgery which probably would be a nephrectomy.

Question: Dr. Chute what do you do with people who have intermittent hematuria with no other findings.

Answer : Masterful inactivity and guinea pig inoculation for tuberculosis are the best things to do. It is best to see the patient when he is bleeding. I have had a case which was treated with nephrectomy who bled enough that he required transfusion, in such a case as this a stain is of value; however, it is better for malignant tumors of the bladder; carcinoma of the prostate is not found well by this method and it is better to spin down cells from the first morning urine specimen, or massage a little of the tissue out of the prostate. In upper urinary tract papillary tumors this method picks them up well; the results with hypernephroma are about 50%.

Question: What do you think of perirenal pneumography in regards to its potential dangers.

Answer : Most people feel it is dangerous. I have done a few and think it is probably O.K.

Case # 5: This is a 22 year old white male admitted with frequency, urgency, disuria and left flank pain for one week. He had had a previous episode with no treatment. Urinalysis showed red blood cells, white blood cells and bacteria. I.V.P. showed dilatation of the left kidney and ureter. A ureterogram showed a left ureteroceles. Cystoscopy revealed the protrusion of the ureter into the bladder. Would you comment on this case.

Comments by Dr. Chute: This case might be treated by excision and reimplantation of the ureter to the bladder. I do not think that splitting of the ureteral orifice would be of any value.

Case # 6: This is a 24 year old white male who was admitted with pain of the left flank with radiation into the groin. His temperature ranged between 100 and 103 degrees. He had anorexia, nausea, vomiting chills and had been sick 24 hours prior to hospitalization. Physical examination showed tenderness in the left flank and the anterior portion of the LLQ. Urinalysis showed red blood cells, white blood cells and many hemolytic staphylococcus area. X-ray examination showed that two ureteral catheters were able to pass the stone in the left ureter. Injection of the dye shows enlargement of the left kidney and partial obstruction due to the presence of the stone in the ureter.

Question: What would you do in such a case?

Answer : Get this patient in shape and operate him right away for removal of the stone from the ureter. At operation it is a good idea to move the stone up 1" to 2" in the ureter and take it out through tissue that is not inflamed. This heals better than inflammatory tissue, however, in moving the stone around there is always some danger in losing it.

Question: How would you treat a chronic ureteritis, following passage of the stone.

Answer : I know of no specific therapy; I would keep this patient on mild chemo-therapy for several months until the symptoms clear up.

Question: Do you have a criterion for size of ureteral stone for surgery.

Answer : No, I do not. The most important thing is the surface of the stone, if it is of a smooth texture it is much more likely to pass than one that is rough or has many points. This is also necessary for prognosticating the length of time necessary for a stone to pass.

XXI. Fat Content Reconstituted Milk - Colonel I. R. Pollard, VC, Veterinary Consultant, GHQ, FEC



Studies made by Trout, Brunner and Lucas at the Michigan Experiment Station indicate that the Babcock test is not entirely accurate for determining the fat content of reconstituted milk. The test generally shows the fat content to be somewhat lower than it actually is (to the extent of 0.25%) as determined by other methods.

All veterinary officers, laboratory technicians and sanitary inspectors making determinations of reconstituted milk should be governed accordingly

XXII. Tropical Medicine Course - Information Published in The Bulletin of the U. S. Army Medical Department, July 1949



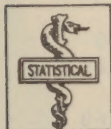
A postgraduate course in tropical medicine will be conducted by New York University Postgraduate Medical School, beginning in October 1949. This is a full-time, intensive eight-week course consisting of lectures, laboratory exercises, and clinical demonstrations covering etiologic agents, arthropod vectors, pathology, diagnosis, and prevention. The subjects to be covered include infections caused by viruses, rickettsiae, bacteria, fungi, spirochetes, protozoa, and helminths; nutritional diseases, tropical ophthalmology, dermatology, sani-

tation, and physiologic problems of the Tropics. It is not contemplated that any officer will be returned to the zone of interior specifically for the purpose of attending this course. Medical officers whose tour of duty expires in September or October may make application through channels to reach the Surgeon General, Department of the Army, Washington 25, D.C., Attention: Chief, Career Guidance Branch, Personnel Division, not later than 15 August 1949. Selection will be based on the applicant's qualifications and career pattern.

PART III

STATISTICAL

Evacuation:



1. Tabulated below are the number of patients evacuated from the major commands to the ZI during the four report weeks in June and the number of patients awaiting evacuation as of 24 June 1949:

	<u>BY AIR</u>	<u>BY WATER</u>	<u>TOTAL</u>	<u>PNTS AWAITING EVAC</u>
JAPAN	73*	4*	77*	331
MARBO	53	1	54	0
PHILCOM	18	1	19	3
RYCOM	31	6	37	28
FEC	<u>175</u>	<u>12</u>	<u>187</u>	<u>362</u>

* Includes 3 patients who originated in Korea.

2. Evacuations of military personnel per thousand strength for the period of 28 May to 24 June were as follows:

JAPAN	.47	PHILCOM	1.9
KOREA	9.4	RYCOM	1.4
MARBO	2.6	FEC	.86

Hospitalization:

1. The bed status as of 24 June 1949 was as follows:

	<u>Total T/O Beds Authorized</u>	<u>Total T/O Beds Established</u>	<u>Total T/O Beds Occupied</u>
JAPAN	4,650	4,527	2,524
KOREA	300	0	0
MARBO	775	606	169
PHILCOM	1,250	1,250	1,012
RYCOM	750	443	338
FEC	<u>7,725</u>	<u>6,826</u>	<u>4,043</u>

2. The percent of T/O beds and established beds occupied as of 24 June 1949 was as follows:

	<u>Percent Authorized T/O Beds Occupied</u>	<u>Percent of Established Beds Occupied</u>
JAPAN	54	56
KOREA	0	0
MARBO	22	28
PHILCOM	81	81
RYCOM	45	76

3. Admission rates per thousand troops per annum for the four week period ending 24 June 1949 were as follows:

	<u>FEC</u>	<u>JAPAN</u>	<u>KOREA</u>	<u>MARBO</u>	<u>PHILCOM</u>	<u>RYCOM</u>
All Causes	539	600	593	273	504	432
Disease	487	547	547	210	439	392
Injury	52	52	47	63	65	40
Psychiatric	13	14	12	11	12	8.8
Common Respiratory Diseases	44	57	12	20	42	0
Influenza	.38	.22	4.9	0	1.8	0
Primary Atypical Pneumonia	4.2	3.5	7.4	3.0	0	9.4
Common Diarrhea	2.2	1.7	12	.74	14	0
Bacillary Dysentery	.15	.11	0	0	1.8	0
Amebic Dysentery	0	0	0	0	0	0
Malaria, new	7.8	6.5	78	0	1.8	5.9
Infectious Hepatitis	3.1	3.6	2.5	0	11	.59
Mycotic Dermatoses	4.2	5.9	0	0	1.8	0
Rheumatic Fever	1.2	1.4	0	0	1.8	.59
Venereal Diseases	147	155	252	16	93	202

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Organization of the Medical Section, GHQ, FEC

The following is a list of commissioned personnel currently assigned or attached to the Medical Section:

Major. Gen. Edgar Erskine Hume
Colonel Richard H. Eckhardt, MC
Major James L. LaCombe, MSC

Chief Surgeon
Deputy Surgeon
Executive Officer

ADMINISTRATIVE DIVISION

Lt. Elvis E. Bates, MSC
WOJG Ernie L. Barker

Director
Administrative Assistant
and Chief Clerk

PLANS AND OPERATIONS DIVISION

Lt. Col. Allen J. Blake, MSC
Captain Vincent I. Hack, MSC
Captain James D. Grindell, MSC
Lt. Maurice F. Watson, MSC
WOJG A. H. McIntire

Director
Publications Officer
Medical Records Officer
Plans & Operations Officer
Administrative Assistant

SUPPLY AND FISCAL DIVISION

Lt. Col. E. W. Partin, MSC
Major Glenn C. Irving, MSC
Captain E. T. Brown, MSC

Director
Deputy Director
Chief, Fiscal Branch

PERSONNEL DIVISION

Lt. Col. Charles Raulerson, MSC
Captain Vernon H. Loisel, MSC

Director
Deputy Director

DENTAL SURGEON

Colonel Melville A. Sanderson, DC

CONSULTANTS

Colonel Irby J. Pollard, VC
Colonel Robert E. Blount, MC
Lt. Col. A. P. Long, MC
Lt. Col. Harlan H. Taylor, MC
Major Mildred I. Clark, ANC
Major Kermit E. Jones, MSC

Veterinary
Medical
Preventive Medicine
Surgical
Chief Nurse
Sanitary Engineer



The Chief Surgeon extends an invitation to all personnel of the Medical Department to prepare and forward, with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted. Copy should be forwarded so as to reach the Medical Section, GHQ, FEC, not later than the 10th of the month preceding the issue in which publishing is desired.

Capt. Vincent I. Hack, Editor